3.774 Final
The property allowance determined under Section 3.500 and ancillary add-ons determined under Section 3.800 shall be added to the rates selected under Sections 3.772 or 3.773 above. The sum shall be the payment rates for the facility.

See pp. 29.a, and 29.b.

3.775 Special Allowances for Facilities Operated by Local Units of Government

A. In recognition of the unique nature of nursing homes operated by local units of government, local government-operated homes are eligible to apply for supplemental funding. Total supplementary funding under this allowance shall not exceed the amount in subsection B. The amount of funding awarded to a home shall be based on the methodology for payments received under this Section in SFY 2000.

1. In order to participate in the supplement, the home must have on file with the Department and/or submit the following materials:

   a. A cost report as required in Section 1.170.

   b. A supplemental award application form.

2. Supplemental funds awarded to the home will be made in lump sum payment(s).

3. Total supplemental funding shall not exceed $40,100,000. The Department shall reduce the supplemental funding to the local units of government if it determines that the aggregate payments to nursing homes under these methods would exceed the Medicare upper limit.

B. Beginning with State Fiscal Year 2001 (July 1, 2000 – June 30, 2001) subject to the availability of county, State, and Federal funds, and based upon a transfer agreement and the subsequent transfer of funds, the Department will make supplemental payments in addition to the amounts under Section A, to government operated nursing homes as provided in subsections 1 and 2.

1. To qualify for exceptional payments under the Medicaid program, a nursing home must meet the following criteria:

   a. Meet the participation requirements set forth in Section A; and

   b. Based on the home's Fiscal Year 1999-00 Medicaid cost report either:

      i) provide at least 108,000 days of care to Medicaid residents and incur a gross deficit for Medicaid of at least $3 million; or

      ii) provide between 80,000 and 108,000 days of care to Medicaid residents and incur a gross deficit for Medicaid of at least $4.5 million.

2. Local government-operated homes qualifying for exceptional payments under subsection 1 will receive an exceptional nursing home payment determined as follows:

   a. For each State Fiscal Year, the Department will calculate the maximum additional payments it can make in conformance with 42 CFR 447.272;

   b. The Department will determine the total additional payments to be made to qualifying nursing homes in a manner not to exceed the maximum amount determined in 2.a;

   c. The Department will determine the total Medicaid costs for each qualifying nursing home using the most recent cost reports on file with the Department;

   d. The Department will divide the Medicaid costs for each qualifying nursing home by the total Medicaid costs for all qualifying nursing homes to determine each qualifying nursing home's payment factor; and

   e. The Department will determine each qualifying nursing home's exceptional payment amount by multiplying the nursing home's payment factor calculated in 2.d by the total additional payment amount determined in 2.b to establish the exceptional payment for the nursing home.

3.775 Special Allowances for Facilities Operated by Local Units of Government

A. In recognition of the unique nature of nursing homes operated by local units of government, local government-operated homes are eligible to apply for supplemental funding. Total supplementary funding under this allowance shall not exceed the amount in subsection 3.

1. In order to participate in the supplement, the home must have on file with the Department and/or submit the following materials:

   a. A cost report as required in Section 1.170.

   b. A prospective supplemental award application form.

2. Supplemental funds awarded to the home will be made in lump sum payment(s).

3. Total supplemental funding shall not exceed $40,100,000. The Department shall reduce the supplemental funding to the local units of government if it determines that the aggregate payments to nursing homes under these methods would exceed the Medicare upper limit.

4. The following methodology will be used to distribute funds under this Section:

   a. Each facility owned and operated by a local unit of government will submit the following:

      1. Cost report as required under Section 1.170
      2. Application for supplemental award

   b. Based upon the cost report and the rates established under the Methods, the Department will determine:

      1. The Projected Direct Care Operating Deficit (DCOD)
      2. The Projected Overall Operating Deficit (OAOD)
      3. The Eligible Direct Care Deficit (EDCD) (Equal to the lesser of the DCOD or the OAOD)

      All deficits in this section will be reduced by any wage pass-through supplement made under Section 3.780. The Department will issue a report to each applicant facility detailing its DCOD and OAOD.

   c. The Department will distribute $40,100,000 in supplemental funding as follows:

      1. The mean EDCD will be determined for all eligible facilities.
      2. Basic Direct Care supplements will be allocated to each facility up to the mean EDCD.
      3. If the sum of the Basic Direct Care supplements is less than $40,100,000, the remaining funding will be allocated proportionately to the facilities with deficits above the mean EDCD based upon each facility's remaining EDCD.
      4. If the sum of the Basic Direct Care supplements is more than $40,100,000, each facility's supplement will be proportionately discounted to bring the total down to $40,100,000.
      5. The supplement to any facility may not exceed its EDCD.
      6. Supplemental funds will be made in lump-sum payment(s).

B. Beginning with State Fiscal Year 2001 (July 1, 2000 – June 30, 2001) subject to the availability of county, State, and Federal funds, and based upon a transfer agreement and the subsequent transfer of funds, the Department will make supplemental payments in addition to the amounts under Section A., to government operated nursing homes as provided subsections 1 and 2.

1. To qualify for exceptional payments under the Medicaid program, a nursing home must meet the following criteria:

   a. Meet the participation requirements set forth in Section A; and

   b. Based on the home's Fiscal Year 1999-00 Medicaid cost report either:

i. provide at least 108,000 days of care to Medicaid residents and incur a gross deficit for Medicaid of at least $3 million; or

ii. provide between 80,000 and 108,000 days of care to Medicaid residents and incur a gross deficit for Medicaid of at least $4.0 million.

2. Local government-operated homes qualifying for exceptional payments under subsection 1 will receive an exceptional nursing home payment determined as follows:

   a. For each State Fiscal Year, the Department will calculate the maximum additional payments it can make in conformance with 42 CFR 447.272;

   b. The Department will determine the total additional payments to be made to qualifying nursing homes in a manner not to exceed the maximum amount determined in 2.a.;

   c. The Department will determine the total Medicaid costs for each qualifying nursing home using the most recent cost reports on file with the Department;

   d. The Department will divide the Medicaid costs for each qualifying nursing home by the total Medicaid costs for all qualifying nursing homes to determine each qualifying nursing home's payment factor; and

   e. The Department will determine each qualifying nursing home's exceptional payment amount by multiplying the nursing home's payment factor calculated in 2.d. by the total additional payment amount determined in 2.b. to establish the exceptional payment for the nursing home.

Effective 07-01-00

3.780 Wage Pass-Through Supplement

Effective July 1, 2000, facilities may receive a supplement to the rate which represents an increase in wages or salary and fringe benefits for nurse assistants or additional staff hours of nurse assistants and resident living staff for ICF-MRs. A maximum per diem supplement shall be calculated by dividing the total of nursing assistants and residential living staff in ICF-MRs wages or salaries of the facility by the total number of adjusted patient days of the facility and multiplying the result by 5%. Facilities' wages, salaries and patient days for this calculation will come from the base cost reporting period in Section 1.302. The maximum payment shall be the per diem maximum above multiplied by 365 days by the average number of Medicaid residents, The total cost of this supplement for all facilities shall not exceed $11,078,600. Facilities must apply for the wage pass-through supplement.

The Department may audit supplemental cost reports from the facilities to ensure the supplement was used appropriately. The Department shall take into account the following factors:

- The fact that the wage supplement percentage increase is based only on wages and salaries, while the cost comparison also includes fringe benefits
- Any decrease or increase in the facility's expenditures for contracted labor services
- Any change in the facility's acuity levels
- Whether or not the facility's reporting period corresponds to the supplement payment period
- Any other factor that the Department determines is relevant and that is readily available in the data base of the Department. These factors can include, but are not limited to, significant discrepancies between the facility's base cost report and the wage pass-through supplemental report, or otherwise may not accurately reflect actual increases in wages, fringes and benefits or increased staff hours.

If the Department determines that a wage-pass through supplement was not expended as required, it may recoup that part of the supplement.

Addenda

The wage pass-through supplement will not recognize cost increases in purchased services .

If total awards exceed $11,078,600 all awards will be reduced proportionately.

The total amount paid to a facility will be the lower of the 5% maximum calculated above or the actual increased expenses incurred between July 1, 2000, and June 30, 2001.

3.790 Purchased Relocation Services

Payment for relocation services may be paid as a lump sum, in addition to the daily payment rate, if all of the requirements listed below are met.

- The relocation plan(s) must be ordered by the Department
- The Department must approve the contractor performing the services.
- Only services such as assessment of the resident for alternate placements, preparing contracts for community-based services and developing the community-based care provided by and paid to an outside contractor are allowable. All staff costs are allowable in the Methods and are not eligible for the lump sum payment.
- The amount allowed must meet all Departmental contracting limits.

The Department will pay the Medicaid portion of the allowed Purchased Relocation Services. The percentage of residents that were Medicaid during the month prior to the relocation order will be used as the Medicaid portion. The Department may, at their sole

Example: The Nursing Home receives a relocation order from the Department on July 15. They hire Apex Relocation Services to relocate all 100 residents in the next 60 days for a cost of $15,000. The Department approves the contract with Apex and the contract amount of $15,000. During June, 75 of the 100 residents were paid through Medicaid. Therefore, $11,250 ($15,000* 75%) will be paid to The Nursing Home as a lump sum.

If this section does not apply, the relocation services will be included in the cost report and paid accordingly.

3.800 ANCILLARY BILLABLE ITEMS

3.801 Medical Transportation

Medical transportation may be separately billed by a nursing home provider as an ancillary. Billings may not exceed the nursing home's actual cost. A per patient day ancillary add-on to the payment rate may be allowed for the cost of transportation services, but not to exceed the amount which would have been separately billable by the facility. The Department shall retain its authority under s. 49.45(10), Wis. Stats., to modify this paragraph.

3.802 Oxygen

A nursing home may bill for oxygen in cubic feet, pounds, tanks or for the daily rental of oxygen concentrators. The nursing home must use the claim form approved by the Department for oxygen billing. The nursing home will be subject to maximum fees for these services. Prior authorization is required for more than 30 days' rental of an oxygen concentrator for a resident.

3.810 Add-Ons for Separately Billable Items

3.811 Ancillary Add-Ons

A per patient day add-on to the daily rate may be allowed for the cost incurred by the facility for specifically identified covered services and materials which could be billed separately to the Medicaid Program by an independent provider of service. These services and materials must be available to all Medicaid recipients of the facility. If some portion of the services and materials must be supplied by an outside provider, the facility is responsible for payment to the outside provider.

The maximum amount allowed a facility for an add-on shall be the estimated maximum reimbursement available to independent providers for such services and materials when billing the Medicaid Program separately. The Department may exclude all costs in excess of this maximum. Such costs shall be from the reporting period(s) specified by the Department. If an add-on is approved, then neither the facility nor independent provider or providers of service may bill or charge the Medicaid Program separately for the material or services which are covered by the add-on. If a special need arises, i.e., something not covered by the add-on for any resident, the facility must receive approval from the Department in advance, in order for an independent provider to be reimbursed for the service or material.

NOTE: Each facility with an ancillary must demonstrate that the add-on to the daily rate is equal to or less costly than if the service was reimbursed to an independent provider through separate billings. If a facility requests a new ancillary add-on, the facility must demonstrate to the Department that the add-on meets the requirement of this section before the add-on is approved. The method of reporting the estimated expenditure shall be specified by the Department.

3.812 Adjustment for Changes in Practice

It is possible that a facility may wish to begin or resume billing some services or materials separately, after having had ancillary add-ons previously incorporated into its daily rate. If that occurs, the Department may make a reasonable and appropriate off-setting reduction to the facility's previous or current payment rate to exclude an ancillary add-on for the service. THE FACILITY SHALL NOTIFY THE DEPARTMENT OF THE CHANGE 30 DAYS PRIOR TO THE PROPOSED EFFECTIVE DATE.

3.900 REIMBURSEMENT OF STATE-OPERATED FACILITIES

3.910 General

The state-owned nursing facilities and ICF-MRs serve a unique population of residents in Wisconsin. Determination of payments will be guided by the provisions below and by the appropriate sections of state statute.

3.920 Direct Care, Support Services Administrative and General, Fuel and Utilities and Property Tax

The maximums and limitations in Sections 3.100 through Section 3.400 shall not be applied in determining payments to state-operated facilities. The amount of the final payment shall be based upon the actual and allowable costs in the cost reporting period. Interim rates and cost reconciliation procedures are described in Sections 3.960 and 3.980.

3.930 Ancillary Add-Ons
Actual and allowable ancillary expenses as described under Section 3.800 for a time period established by the Department shall be used to calculate the final ancillary add-on costs. Interim add-ons will be set as described in Section 3.960. Underpayments or overpayments for ancillary add-on costs shall be included in the reconciliation described in Section 3.980. The maximums and limitations in Section 3.610 shall not be applied in determining payments to these facilities.

3.940 Capital Costs
Actual and allowable capital expenses for the cost reporting period shall be used to calculate the final property allowance. The property allowance shall be subject to reconciliation under Section 3.980.

3.950 Reporting Limitations
The facilities shall be subject to all cost reporting requirements, and payments shall be limited to allowable costs described in Section 1.200. The costs of teaching and vocational counseling services rendered residents under age 22 as part of an active treatment plan are only allowable in facilities licensed as ICF-MRs. The facilities will maintain adequate records so that audits of costs may be conducted to determine payable costs.

3.960 Interim Payment Rates
Interim payment rates may be established and will be subject to the cost reconciliation under Section 3.980.

3.970 Reimbursement Limitation
Total reimbursement for the payment rate year for state-owned facilities for patient care shall not exceed the Medicare upper limit, the amount allowed by state law, or the actual allowable cost, whichever is less.

3.980 Cost Reconciliation
A cost reconciliation will be conducted at the end of each state-owned facility's fiscal year. If payment at the interim rates does not exceed the Medicare upper limit, then the facility will be reimbursed the difference. If the payments at the interim rates are above the Medicare upper limit, then the difference will be recovered. However, in no case shall the total Medicaid payment exceed the limitations described in Section 3.970.

SECTION 4.000 SPECIAL PAYMENT RATE ADJUSTMENTS AND RECALCULATIONS

4.100 RETROACTIVE RATE ADJUSTMENTS

4.110 Retroactivity

The Department has the authority to retroactively adjust the daily rate in such circumstances as audit adjustments, errors in reporting, errors in calculations, implementation of administrative formula provisions, and implementation of rules enacted under s. 49.45(10), Wis. Stats.

4.115 Administrative Reviews and Appeals

Sections 4.110 through 4.150 do not apply to administrative reviews under Section 1.800 or to appeals under Section 1.400 or Section 1.700. The time limits within which administrative reviews or appeals must be filed are determined under the relevant section, rule, and guidelines.

4.120 Material Adjustments

Only audit adjustments and/or corrections of errors which have a combined net material impact on rates and payments for services will be incorporated into the rates. "Material" is defined as the combined net increase or decrease being equal to or greater than an average change of $.050 per patient day. The average change shall be calculated on a weighted average of the change in each level of care payment rate using the patient days from the calculation of the average base rate (See Section 3.710). The materiality test will be applied separately each time payment rates are recalculated for the correction of errors or audit adjustments with the newly-adjusted rates being compared to the rates being corrected or adjusted.

4.130 Within 150 Days

A provider must deliver written notice of errors to the Department within 150 days of the date of the first rate approval letter in order for any corrected rates to take effect on the original effective date of the rates in error. A postmark date shall be considered delivery date. The provider will be limited to only one such retroactive adjustment per rate effective period in order to correct errors in reported data. Departmental corrections to the rate calculation mechanics of the Department shall not be limited to one such retroactive adjustment. Notice or approval of a corrected rate does not initiate a new 150-day period.

If errors are found by the Department, increased corrected rates will be effective on the first of the month following the month in which the error was found and decreased corrected rates will be effective on the original effective date of the rates being corrected. If such errors are found coincident to a notice from the provider of some other errors, then corrections for the findings of the Department shall be incorporated with and allowed to be retroactively effective in conjunction with the corrections resulting from the notice from the provider.

4.140 After 150 Days

If the provider delivers written notice of errors to the Department more than 150 days after the date of the first rate approval letter, corrected increased rates will be effective the first of the month following the month in which the notice was delivered to the Department. Corrected decreased rates from such notice shall be effective on the original effective date of the corrected rates. A postmark date shall be considered delivery date.

If errors are found by the Department, corrected increased rates will be effective the first of the month following the month in which found by the Department. Corrected decreased rates shall be effective on the original effective date of the rates being corrected. If such errors are found coincident to a notice from the provider of some other errors, then corrections for the findings of the Department shall be incorporated with and be effective in conjunction with the corrections resulting from the notice from the provider.

4.150 Audits

Any findings of the Department in the course of an audit shall be considered findings coincident to any written notice of errors delivered by the provider to the Department in the course of the audit. Such corrections submitted by the provider shall be taken into consideration in conjunction with and incorporated with any findings of the Department when determining audit adjusted payment rates. An audit shall be considered completed on the date of the approval letter of the audit adjusted payment rates. This completion date initiates the 150-day period described in Section 4.130.

4.200 CHANGE OF OWNERSHIP

4.210 No Rate Change for New Owner

There shall be no payment rate recalculation due to the change of ownership of a facility or operation which occurs during the payment rate year described in Section 1.130. The new provider will be paid the rate which the former owner was paid or would have been paid if no change of ownership had occurred, unless other provisions of this Section 4.000 allow adjustments to the payment rate. If the change of ownership occurred prior to the payment rate year, July 1 payment rates shall be determined based on a cost reporting period allowed under Section 1.302.

4.220 Prior Owner's Cost Report Required

The cost report for the period during which the facility was operated by the previous owner is still required and must be submitted to the Department unless the Department determines the cost report is not needed. THE NEW OWNER SHOULD ASSURE THE PRIOR OWNER'S COST REPORT IS SUBMITTED. The cost report is presumed to be needed in order for the Department to obtain sufficient data for a full twelve month base cost reporting period allowed under Section 1.302. In those rare instances where it may be impossible to obtain the prior owner's cost report, the Department may determine it is not needed if the cost reporting period for the new owner allowable under Section 1.302 covers a period of at least six months. If the prior owner's cost report is needed, but not submitted, the new provider's rates for the payment rate year specified in Section 1.130 will default to the facility's June 30th rate of the prior payment rate year, exclusive of any amounts for ancillary add-ons and Nursing Home Appeals Board awards and special allowances for local government operated facilities. The Department may reduce those rates by no more than 25.0% if deemed appropriate.

4.230 Property Tax

The property tax allowance shall not be adjusted to recognize a change in tax status upon a change of ownership.

4.300 PAYMENT RATES FOR NEW FACILITIES

4.301 General

Payment rates for a new facility will be established under the rate calculation provisions of Section 3.000. The rate computation will consist of two phases: (1) retrospective rates for the start-up period, and (2) post start-up period adjusted rates. The Department will establish interim rates until rates can be finalized under this section. New facilities are defined in Section 1.305. The Department may deny approval of any rates if any required Chapter 150 approval was not obtained. The Chapter 150 rate maximum per Section 1.600 shall apply, if applicable, to the new facility. Allowable costs will be deflated and inflated as appropriate with the indices in Section 5.300 and the provisions of the current Methods applied. The property allowance shall be calculated under the provisions of Section 3.500.

The provisions of Sections 4.300 through 4.360 shall not apply to the full or partial conversion of an NF to ICF-MR certification.

4.310 Start-Up Period

The start-up period shall be the twelve-month period beginning on the first of the month following the month in which the facility was licensed. A facility certified for the Medicaid Program after this twelve-month period shall be considered to have completed its start-up period.

4.320 Payment Rates During the Start-Up Period

Payment rates for the start-up period shall be retrospectively established based on one or more cost reports for the start-up period. The cost reporting period shall: (1) begin on, or within the five calendar months after, the date of certification for Medicaid, and (2) end on, or within the five calendar months after, the end date of the start-up period. The payment rates shall not be effective earlier than the certification date and shall lapse not later than at the end of the start-up period.

The minimum patient days for the administrative expense component (Section 3.230), the fuel and utility allowance (Section 3.300), the property tax allowance (Section 3.400), and the property allowance (Section 3.500) shall be the greater of patient days at 50.0% occupancy of average licensed beds or adjusted patient days during the cost reporting period.

4.330 Payment Rates After the Start-Up Period

After completion of the start-up period, rates for a new facility shall be reestablished based on at least a six-month cost report which will begin after the end of the start-up period or after the end of the cost reporting periods used under Section 4.320. The minimum patient day occupancy standards under Section 3.000 shall apply.

4.332 Modified Cost Report Period
The Department may modify the above start-up period and cost reporting requirements for special situations or to accommodate the fiscal year of a provider to permit more efficient or reliable cost reporting. Whenever possible, fuel and utility expense should cover a twelve-month period pursuant to Section 3.360.

4.333 Base Rates
The base rates for a newly-licensed facility are described in Section 3.722, item 4.

4.335 July 1 Payment Rates
A base cost reporting period shall be designated by the Department for establishing a new facility's payment rates for July 1 of the payment rate year described in Section 1.314. If the start-up period includes the July 1 date, then the July payment rates shall be established under the retrospective provisions for the start-up period. If the cost reporting fiscal year specified in Section 1.302 begins before or during the start-up period, then the Department may designate a more current base cost reporting period for July rates.

4.350 Inflationary Adjustment of Expenses
Cost data from any cost reporting period described above will be inflated or deflated to the common period described in Section 1.303.

4.360 Property Tax Allowance
The property tax allowance shall be based on the provisions of Section 3.400. Nevertheless, the provider may request the property tax allowance for a new facility to be adjusted if the expense in the previous tax allowance had been based on an assessment date prior to the month of licensure. The adjustment shall be effective on January 1 of the year in which payment of the tax or municipal service fees are due but not earlier than the first of the month in which the request is received by the Department. The adjustment shall only consider current expenses, without any inflationary adjustment, and patient days from the cost report period that was used for the support services allowance in the January 1 payment rate.

4.400 PAYMENT RATES FOR SIGNIFICANT INCREASES IN LICENSED BEDS

4.401 General
The Department may require or a provider may request the payment rate to be reestablished under the provisions of Section 3.000 when a provider significantly increases its unrestricted use licensed beds. The rate computations will consist of two phases: (1) retrospective rates for the start-up period, and (2) post start-up period adjusted rates.

The Department may establish interim rates until rates can be finalized under this section. A significant increase in licensed beds is defined in Section 1.304. The Department may deny approving any adjusted rates if any required Chapter 150 approval was not obtained. The Chapter 150 rate maximum per Section 1.600 shall apply, if applicable, to the expanded facility. The property allowance shall be recalculated under the provisions of Section 3.500.

The provisions of Sections 4.400 through 4.460 shall not apply to the full or partial conversion of an NF to ICF-MR certification.

4.410 Start-Up Period
The start-up period shall be the twelve-month period beginning on the first of the month following the month in which the new beds were licensed.

4.420 Payment Rates During the Start-Up Period
Application of this section is optional. Payment rates for the start-up period may be retrospectively established based on one or more cost reports for the start-up period for any or all applicable payment allowances. The cost reporting period shall: (1) begin on, or within the five calendar months after, the beginning date of the start-up period, and (2) end on, or within the five calendar months after, the end date of the start-up period. The adjusted payment rates shall be effective as of the date of amended licensure.

The minimum patient days for the administrative expense component (Section 3.250), the fuel and utility allowance (Section 3.300), the property tax allowance (Section 3.400), and the property allowance (Section 3.500) shall be the greater of adjusted patient days or patient days at the minimum occupancy rate described here. The minimum occupancy rate shall be based on: (1) 50.0% of the increase in licensed beds, and (2) the average daily occupancy in the six calendar months immediately preceding the increase in licensed beds during which no substantial number of licensed beds were out-of-use due to any renovation or construction. The occupancy rate in (2) above must be 90.5% or greater.

4.430 Payment Rates After the Start-Up Period
After completion of the start-up period, rates for a significantly expanded provider may be reestablished based on at least a six-month cost report which will begin after the end of the start-up period or after the end of the cost reporting period used in Section 4.420. The minimum patient day occupancy standards under Section 3.000 shall apply. Section 4.430 may be applied to the significantly expanded provider which does not receive a retrospective adjustment under Section 4.420.

4.432 Modified Cost Report Period
The Department may modify the above cost reporting requirements for special situations or to accommodate the fiscal year of a provider to permit more efficient or reliable cost reporting. Whenever possible, fuel and utility expense should cover a twelve-month period pursuant to Section 3.360.

4.433 Base Rates
The base rates for a significantly expanded facility are described in Section 3.722, item 3.

4.435 July 1 Payment Rates
A base cost reporting period shall be designated by the Department for establishing an expanded facility's payment rates for July 1 of the payment rate year described in Section 1.314. If the start-up period includes the July 1 date, July payment rates may be established under the retrospective provisions for the start-up period. If the cost report for the fiscal year specified in Section 1.302 begins before or during the start-up period, the Department may designate a more current base cost reporting period for July 1 rates.

4.460 Property Tax Allowance
The property tax allowance shall be based on the provisions of Section 3.400. Nevertheless, the provider may request the property tax allowance for an expanded facility to be adjusted if the expense in the previous tax allowance had been based on an assessment date prior to the month of licensure. The adjustment shall be effective on January 1 of the year in which payment of the tax or municipal service fees are due but not earlier than the first of the month in which the request is received by the Department. The adjustment shall only consider current expenses, without any inflationary adjustment, and patient days from the cost report period that was used for the support services allowance in the January 1 payment rate.

4.500 PAYMENT RATES FOR SIGNIFICANT DECREASES IN LICENSED BEDS

4.501 General
A provider may plan to significantly decrease its number of unrestricted use licensed beds. The Department may require or the provider may request payment rates to be reestablished. If the provider makes the request, the provider must notify the Department in writing prior to the effective date of the reestablished rates and must relinquish the future use of a significant number of licensed beds. Any future use of the relinquished beds must be approved, if required, under Chapter 150, Wis. Stats. The Department may deny rate adjustments under this section if it determines the provider's decrease is not desirable or appropriate.

If the reduction involves an extended and major phase-down, the provider may elect to have rates established under the provisions of Section 4.560 below. If Section 4.560 is not applied, the rate computation will consist of two phases: (1) retrospective rates for the phase-down period, and (2) post phase-down adjusted rates. A significant decrease is defined in Section 1.304. The property allowance shall be recalculated, subject to the targets, maximums and ratios described in Section 3.500.

The provisions of Sections 4.500 through 4.560 shall not apply to the full or partial conversion of an NF to ICF-MR certification.

4.501(a) Sale of Beds
A rate adjustment will be made under this section only when a provider has surrendered the right to license these beds for reallocation through the Resource Allocation Program (RAP). Thus, where a provider has sold or transferred his right to license beds, without going through the RAP process, the phase-down and facility closing provisions will not be used to adjust Medicaid rates for the facility that is reducing licensed bed capacity.

The costs of acquiring the right to license beds from another provider are non-reimbursable costs.

4.510 Phase-Down Period
The phase-down period is that time period during which the resident population may be reduced and during which licensed beds are being reduced to the objective bed capacity. The provider shall submit a written plan for the phase-down acceptable to the Department. The plan must specify the objective licensed bed capacity, the expected date by which any phase-down of the resident population is to begin, the amount of the phase-down, and the expected date by which the license will be amended to the objective capacity. The Department shall establish the beginning and ending dates of the phase-down period which may be modified as needed during the phase-down.

4.520 Payment Rates During the Phase-Down Period
Application of this section is optional. Payment rates for the phase-down period shall be retrospectively established under Section 3.000 based on one or more cost reports. No retrospective adjustment shall be available if the phase-down period is less than six months. The cost reporting period(s) shall: (1) begin on, or within the five calendar months before or the five calendar months after, the starting date of the phase-down period, and (2) end on, or within the five calendar months after, the effective date of the amended license at the objective capacity. The retrospective payment rates shall not be effective earlier than the beginning date of the cost reporting period and shall lapse at the end of the reporting period.

The minimum patient days for the administrative expense component (Section 3.250), the fuel and utility allowance (Section 3.300), the property tax allowance (Section 3.400), and the property allowance (Section 3.500), shall be the greater of patient days at 96.0% occupancy of the objective licensed bed capacity or adjusted patient days during the cost reporting period.

4.530 Payment Rates After the Phase-Down Period
After a provider's license is amended to the objective licensed bed capacity, payment rates may be reestablished based on at least a six-month cost report acceptable to the Department which will begin after the end of the phase-down period or after the end of the cost reporting period used under Section 4.520. Section 4.530 may be applied to the significantly decreased provider which does not receive a retrospective adjustment under Section 4.520. The minimum occupancy standards in Section 3.000 shall apply for determining payment rates after the phase-down period.

4.532 Modified Cost Report Period
The Department may modify the above cost reporting requirements for special situations or to accommodate the fiscal year of a provider to permit more efficient or reliable cost reporting. Whenever possible, fuel and utility expense should cover a twelve-month period pursuant to Section 3.360.

4.535 July 1 Payment Rates
A base cost reporting period shall be designated by the Department for establishing the decreased facility's payment rates for July 1 of the payment rate year described in Section 1.314. If the phase-down period includes the July 1 date, then the July payment rates may be established under the retrospective provisions for the phase-down period. If the cost report for the fiscal year specified in Section 1.302 begins before or during the phase-down period, then the Department may designate a more current base cost reporting period for July 1 rates.

4.550 Inflationary Adjustment of Expenses
Cost data from any cost reporting periods described above will be inflated or deflated to the common period described in Section 1.303.

4.560 Major Phase-Down
A major phase-down is: (1) a significant reduction in unrestricted use licensed beds, and (2) a reduction of resident population by 15.0% or more. The determination of the extent of the reduction of resident population shall be based on the average daily resident census, including each bed hold day as one full day, during the cost reporting period which would have been used for establishing payment rates in the first month of the phase-down period if no phase-down rate adjustment had been pursued. Payment rates for such a provider shall be negotiated between the Department and the provider. The provisions of Section 3.000 need not be applied for determining such rates.

4.580 Facility Closings
A provider may choose to phase out its nursing home operation. In such cases, the provider may request, or the Department may require, an adjustment to payment rates for the period of the phase-out. The Department may deny rate adjustments under this section if it determines the provider's phase-out is not desirable or appropriate. Payment rates for such a provider shall be negotiated between the Department and the provider. The provisions of Section 3.000 need not be applied for determining such rates.

4.600 CHANGE IN FACILITY CERTIFICATION OR LICENSURE

4.601 General
If a provider changes its certification, including certification in whole or in part as an ICF-MR or licensure level, the Department may require, or the facility may request, payment rates to be reestablished under Section 3.000. Only the direct care allowance under Section 3.100 and the final rates under Section 3.700 will be recalculated, based on a cost reporting period for patient days and for direct care wages, purchased services and supply expenses. In lieu of reporting new supply expenses, previously allowed supply expenses may be used in the recalculation if acceptable to the Department. The rate computations will consist of two phases: (1) retrospective rates for the change-over period, and (2) post change-over period adjusted rates. The Department may establish interim rates until rates are finalized. The Department may deny reestablishing payment rates if any required Chapter 150 approval was not received. The Chapter 150 rate maximum, per Section 1.600, shall apply, if applicable, to the facility.

4.602 Exceptions
The provisions of Section 4.600 do not apply to a facility certified as a skilled nursing facility (SNF) solely acquiring certification as a nursing facility (NF). Section 4.600 delineates provisions for rate adjustments for facility converting to ICF-MR certification.

4.605 Rates Not Reestablished
If rates are not reestablished upon a change in certification or licensure level, then the payment rate for any added level of care shall be the rate from the next lower level of care.

4.610 Change-Over Period
The change-over period shall be at least a six-month period but no more than a twelve-month period beginning on the first of the month following the month in which the change was effective.

4.620 Payment Rates During Change-Over Period
Application of this section is optional, and if it is not applied, then Section 4.610 will apply. Payment rates for the change-over period may be retrospectively established based on one or more cost reports for the change-over period. The cost reporting period shall: (1) begin on, or within the five calendar months after, the beginning date of the change-over period, and (2) end on, or within the five calendar months after, the end date of the change-over period. The adjusted payment rates shall be effective as of the effective date of the applicable change.

4.630 Payment Rates After the Change-Over Period
After completion of the change-over period, rates for a changed provider may be reestablished based on at least a six-month cost report for patient days and for direct care wages, purchased services and supply expenses. Such cost reporting period shall begin after the end of the change-over period or after the end of the optional cost reporting period used under Section 4.620.

4.632 Modified Cost Report Period
The Department may modify the above cost reporting requirements for special situations or to accommodate the fiscal year end, reimbursement period, or other cost reports required in different sections of these Methods to permit more efficient or reliable cost reporting.

4.635 July 1 Payment Rates
A base cost reporting period shall be designated by the Department for establishing a changed facility's payment rates for July 1 of the payment rate year described in Section 1.314. If the change-over period includes the July 1 date, then payment rates for July through the end of the change-over period may be established under the retrospective provisions for change-over period. If the cost report for the fiscal year specified in Section 1.302 begins before or during the change-over period, then the Department may designate a more current base cost reporting period for July 1 rates.

4.650 Inflationary Adjustment of Expenses
Cost data from any cost reporting periods described above will be inflated or deflated to the common period described in Section 1.303.

4.690 Special Care Payments/Non Rate Payments

4.691 Ventilator Dependent and Extensive Care Patients
Ventilator dependent patients who can be transferred from a hospital to a nursing home, may be able to receive a comparable level of service at a lower cost in a nursing home. Upon prior approval of the Department, payment of $350 per day, in lieu of the facility's daily rate, shall be paid for such an individual resident for a period determined by the Department if it has been demonstrated to the satisfaction of the Department that the facility can provide care in accordance with the specific patient's needs. This payment does not apply to patients receiving either Continuous Positive Airway or Bi-level Positive Airway pressure ventilator care. Any such payment or recoupment of same is contingent on care being needed and provided. Payment for related extensive care patients prior authorized for care at the $150 rate before July 1, 1989 will continue to receive this rate, with appropriate continued prior authorization for the payment rate year.